Table of Contents

Introduction

Benefit Options, the State of Arizona's comprehensive employee benefits package, was designed with you and your family in mind.

In this valuable reference guide, we have included explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

The Benefit Options Guide is designed to provide an overview of the Benefit Options Program and the benefits offered through the State of Arizona. The actual benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

Important Contact Information

CONTACT	PHONE NUMBER	WEB ADDRESS	POLICY NUMBER
Medical Plans			
Harrington Benefits (RAN/AMN, Schaller Anderson, Arizona Foundation, Beech Street)	1.888.999.1459	www.myazhealth.com	3J
UnitedHealthcare	1.800.896.1067	www.myuhc.com	705963
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
Dental Plans			
Delta Dental	1.800.352.6132	www.deltadentalaz.com	7777- 0000
Employers Dental Services	1.800.722.9772	www.mydentalplan.net	6300
Fortis Benefits	1.800.443.2995	www.fortisbenefitsdental.com	EA82
MetLife Dental	1.800.942.0854	www.metlife.com/dental	94739
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790 - 1040
Flexible Spending Accounts			
ASI - InfoLine	1.800.366.4827	www.asiflex.com Email: asi@asiflex.com	
ASI - Member Services	1.800.659.3035		
Other Important Numbers			
ADOA Benefits Office 100 N. 15th Avenue, #103 Phoenix, AZ 85007	602.542.5008 or 1.800.304.3687	www.benefitoptions.az.gov Email: azboquestions@azdoa.gov	

Eligibility

The following persons may be eligible for COBRA coverage:

- An employee who had coverage through the State of Arizona and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.
- An employee's legal spouse, as defined by Arizona Statute, who had coverage through the State of Arizona and lost the coverage for any of the following reasons:
  - Death of the employee
  - Termination of the employee's employment for reason other than gross misconduct
  - Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage
  - Divorce or legal separation from the employee
  - The employee becomes eligible for Medicare
- An employee's dependent child who had coverage through the State of Arizona and lost the coverage for any of the following reasons:
  - Death of the employee (parent)
  - Termination of the parent's employment for a reason other than gross misconduct
  - A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage
  - The parents' divorce or legal separation
  - The parent becomes eligible for Medicare or,
  - The dependent ceases to be a dependent child as defined by the Benefit Options program.

The ADOA Benefits Office will determine final eligibility for COBRA coverage.

If you are eligible for COBRA coverage, you have 60 days from the date of COBRA notification or loss of coverage, whichever is later, to elect coverage or you waive your right to COBRA coverage.

Eligible dependent children include:

- Natural, adopted and/or stepchildren under age 19, or under 25 if a full-time student at an accredited educational institution.
- Minors under the age of 19 for whom the employee-member has court-ordered guardianship.
- Foster children under the age of 19.
- Children placed in the employee-member's home by court order pending adoption.
- Natural, adopted and/or stepchildren who were disabled prior to age 19 and a dependent under the Plan at the time of the disability.

Please note: If your dependent child is approaching age 19 and is disabled, immediately contact the ADOA Benefits Office regarding procedures to continue coverage for this dependent. You will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration (SSA) guidelines, that occurred

prior to his or her 19th birthday. Documentation may be required periodically to include a disabled dependent on your plan. Final eligibility will be determined by the ADOA Benefits Office.

Qualified Medical Child Support Order (QMCSO)
If a QMCSO exists, you must continue coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

How Long COBRA Coverage Lasts

If you lose coverage through the State of Arizona plan because of a termination of employment or a reduction in hours, you and your eligible family members may maintain COBRA coverage for a maximum period of 18 months from the date of the event.

If an employee's spouse and/or covered dependents lose their coverage because

- of the employee's death or entitlement to Medicare
- of the employee's legal separation or divorce
- the employee's child is no longer a dependent under the Plan,

the eligible family members may maintain COBRA coverage for a maximum period of 36 months from the date of the event.

By law, these coverage periods may be reduced for any of the following reasons:

- the State of Arizona no longer provides group health coverage to any of its employees;
- you do not pay the amount due for your COBRA coverage on time;
- you or one of your covered family members become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition; or
- you or one of your covered family members become entitled to Medicare.

Extended COBRA Coverage

In addition, during or before an 18-month period of COBRA coverage, the Social Security Administration makes a formal determination that you or a covered dependent spouse or child are totally and permanently disabled, so as to be entitled to Social Security Disability Income benefits, the 18-month maximum period of COBRA coverage can be extended for up to 11 more months, for all qualified beneficiaries who have elected COBRA coverage. The cost of coverage during the additional 11-month period of COBRA coverage may be considerably higher than the cover for the coverage for the first 18 months. This extension is available if:

- the Social Security Administration determines that the individual's disability began no later than 60 days after the employee's employment was terminated or his/her hours were reduced; and

- you or another member of your family notifies the ADOA Benefits Office of the disability determination by the Social Security Administration before the end of the 18-month COBRA coverage period.

Electing Your COBRA Benefits

Upon termination from State Service, employees and eligible dependents will be notified in writing of their COBRA rights and the deadline date for returning their enrollment form(s).

To have the opportunity to continue coverage after a divorce, legal separation, or a child ceasing to be a dependent, the employee and/or affected family member(s) must inform the ADOA Benefits Office in writing no later than 60 days after the event. If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to choose COBRA coverage. When notified that one of these events has happened, the ADOA Benefits Office will provide the covered dependents with the information and forms needed to elect COBRA coverage. Under the law, the covered dependents have at least 60 days from the date they would lose coverage because of one of the events described above, to inform the ADOA Benefits Office that they want to elect COBRA coverage.

COBRA coverage may be elected for some members of the family but not others (including one or more dependents, even if the employee does not elect it), as long as those for whom it is chosen were covered by the Plan on the date of the event (e.g., termination of employment, death, divorce) that led to the loss of regular coverage. A parent may elect or reject COBRA coverage on behalf of dependent children living with him or her. If one of the dependents elects COBRA coverage for him/herself only, the enrollment form must be signed by that dependent unless the dependent is a minor. When the dependent is a minor, the employee-parent must sign the form.

Changing Your COBRA Benefits

If, while you are enrolled for COBRA coverage, you marry, have a child or have a child placed for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA coverage, provided you do so within 30 days after the marriage, birth or placement. Adding a spouse or child may increase the amount you must pay for COBRA coverage.

A Second Qualified Life Event

If you have a second Qualified Life Event while under COBRA coverage and you were eligible for COBRA coverage as the result of an employee's termination (for other than gross misconduct) or the reduction in hours of an employee, you may be granted an extension of coverage for up to 36 months from the date of termination or reduction in hours. The extension applies only to qualified beneficiaries, including children of the employee who were born or adopted while the employee was on COBRA coverage. (Qualified beneficiaries include an employee's spouse who was covered by the Plan

and an employee's dependent children who were covered by the Plan.)

If You and Your Spouse are State Employees
If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect.

Each of you may elect single medical, dental and/or vision plan coverage. **OR,** One of you may elect family medical, dental, and/or vision plan coverage while the other elects no coverage or single coverage, with different insurance plans.

Enrollment

Initial Enrollment

- Fill out the COBRA Enrollment form.
- Send it into the ADOA Benefits Office within 60 days of your eligibility event.

Remember

- To sign and date your completed COBRA Election Notice
- To keep a copy of your completed COBRA Election Notice

Your Contributions to Benefit Options

What Do You Pay?
By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families - both the employee's and the employer's portion - plus an additional 2% administrative fee.

When Do You Pay?
You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums

How Do You Pay?
Payments for COBRA coverage are made directly to the individual plan vendors. Each vendor will bill you for your coverage. All payments must be made out to the vendor. ADOA cannot process these payments.

ADOA and your vendor will not be able to confirm that you are entitled to covered services until the vendor has received your premium for the month in which the care is to be provided.

Medical Plan Features

What is a Plan Administrator?
A Plan Administrator is the contracted organization that processes the medical claims, provides customer service and runs the day-to-day operations of the health plan:

- If you are enrolled with the Arizona Foundation, Beech Street, RAN/AMN, or Schaller Anderson Healthcare networks, your plan administrator is Harrington Benefit Services.
- If you are enrolled with UnitedHealthcare, your plan administrator is UnitedHealthcare.
- The ADOA Benefits Office is the Plan Sponsor *not* the Plan Administrator.

I've heard the terms, "integrated" and "non-integrated". What do they mean?
Integrated and non-integrated describe the way services are provided in each health plan:

- If you are enrolled with Arizona Foundation, Beech Street, RAN/AMN, or Schaller Anderson Healthcare, you are in the non-integrated plan. This means multiple organizations supply the health plan services:
  - Arizona Foundation, Beech Street, RAN/AMN and Schaller Anderson Healthcare provide the networks of hospitals and medical providers.
  - Harrington Benefit Services provides the claims payment processes, day-to-day operations, and customer service.
  - Schaller Anderson Healthcare provides the prior authorization, disease management, and medical review services.
- If you are enrolled with UnitedHealthcare, the integrated plan, UnitedHealthcare provides the following: hospital and provider networks; claims payment processes and day-to-day operations; and prior authorization and disease management services.
- Walgreens Health Initiatives (WHI) is a Pharmacy Benefit Manager and provides pharmacy services for both the integrated and non-integrated health plans.

What is a Pharmacy Benefit Manager?
A Pharmacy Benefit Manager provides the national network of pharmacies; mail-order service; and specialty pharmacy services. A Pharmacy Benefit Manager manages pharmacy benefits in the following ways by providing bulk discounts on medications through the use of a formulary; by reviewing the way medications are used by members; and by implementing targeted programs to reduce overall pharmacy costs. These programs promote the use of cost-effective medications, maximize generic efficiency, and encourage proper utilization. A Pharmacy Benefit Manager also works with physicians to review medications prescribed and look for possible lower cost alternatives.

What is an "EPO" plan and how is this different from a "PPO" plan?
An EPO is an HMO-like plan called an Exclusive Provider Organization. The EPO plan follows the same guidelines as an HMO plan. You must obtain services from a

contracted network provider. A PPO plan is a Preferred Provider Organization and allows in-network and out-of-network treatment. If you obtain out-of-network treatment, you will need to meet a deductible and will pay a percentage of all covered services.

The State offers "open access" in all of the EPO plans. What does this mean?
Open access refers to how you "access" physicians. Instead of getting a referral from your Primary Care Physician (PCP) to see a specialist, you may schedule an appointment directly with a specialist of your choosing. The specialist MUST be contracted within your network. However, if you wish to obtain specialist referrals through your PCP, you may do so.

If my PCP refers me to a specialist or medical provider that is NOT within my EPO network, am I responsible for the medical charges?
Yes. In the EPO plan, all medical services received must be contracted through network medical providers. If your PCP has scheduled an appointment for x-rays, laboratory tests, or specialists, you must make sure they are within your medical network.

If you are enrolled in the PPO plan, you may obtain out-of-network services and pay 30 percent of the covered charge after you have met your deductible.

How do I find out what is covered in the health plan?
Covered benefits are described in a booklet called a Plan Description. A plan description outlines your health insurance coverage and provides information on how claims will be paid, services that require pre-certification, services that are covered and items that are excluded by the health plan. You will receive a copy of the plan description after the beginning of a new plan year. You may also view these descriptions online at www.benefitoptions.az.gov.

I have been contacted by someone and asked if I want to participate in a disease management program. What is disease management?
Disease Management is a voluntary service provided through an organization contracted with the State of Arizona, which assists members with treatment needs for chronic conditions. If you are being treated for any of the conditions listed below, you will be contacted by the Disease Management staff with further information on the program. This is a free service to provide you information, assistance, and resources to manage the following conditions:

- Asthma
- Congestive Heart Failure
- Diabetes
- Perinatal Care (before or after the birth of a baby)

What is Perinatal care? What services are available to me if I am pregnant or planning to become pregnant?
If you become pregnant, you can receive care and education through the Benefits Options Perinatal Program. This program helps future moms and their babies get a healthy start even before pregnancy begins. Resources available include:

- Preconception counseling
- Educational materials on common topics
- Screening and health assessment to help identify high risk pregnancies

- Special management of medical care by health professionals for expecting mothers with high risk pregnancies

** If you are a member of the Arizona Foundation, Beech Street, RAN/AMN network, or Schaller Anderson Healthcare, you may call 1.888.999.1459 and ask for perinatal services through the Schaller Anderson program. If you are a member of UnitedHealthcare, you may call 1.800.896.1067 and ask for information on the UnitedHealthcare pregnancy services.

What is a network service area?
A network service area is the region in which your network is offered:

- The Arizona Foundation PPO plan is offered statewide.
- The Beech Street PPO plan is offered for members living outside of Arizona and will be used as a national travel network if you are enrolled with Arizona Foundation, RAN/AMN, or Schaller Anderson Healthcare.
- The RAN/AMN EPO plan is offered statewide.
- The Schaller Anderson Healthcare EPO plan is offered statewide.
- The UnitedHealthcare EPO and PPO plans are offered in Maricopa, Gila, Pinal, Pima and Santa Cruz counties.

If you are enrolled in an EPO plan, you are covered nationwide for emergencies and urgent care. However, you must obtain routine or scheduled services within your network service area. Members enrolled in the PPO plan are able to obtain out-of-network services nationwide.

What is Coordination of Benefits?
When an employee has more than one health plan or is considered a covered dependent under another plan, benefits are coordinated so that no more than 100 percent of the claim is paid to a medical provider. One plan will be considered primary and the other will be considered secondary. For additional information on how coordination of benefits will be applied, please refer to the appropriate plan description.

Online Features of Medical Plan Information

Members can now review their personal profile, view the status of medical claims, obtain general medical/pharmacy information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, Beech Street, RAN/AMN, or Schaller Anderson Healthcare
Members enrolled with any of the providers above, may view the following information on www.myazhealth.com (you will need to register with a user name and password):

• Personal Profile	Check your eligibility status and personal profile.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Secure Mail	With the "Secure Mail" feature, you may ask questions anytime day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting your personal information over the internet.
• Health Information	Compare hospitals based on quality of care, procedures and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.
• Medline Plus	Medline provides extensive health information on over 650 diseases and conditions; provides a medical dictionary and encyclopedia; information on clinical health trials; and the latest medical research in medicine.
• Provider Search	You may click on your network to research contracted network physicians, hospitals, and medical providers.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claim Forms	You may download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

BCBS (NAU only): *Members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address: www.bcbsaz.com.*

UnitedHealthcare
Members enrolled in UnitedHealthcare can view the following information on www.myuhc.com (you will need to register with a user name and password):

• Personal Profile	Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.
• Provider Search	Find the physicians and hospitals that are convenient and right for you.
• Provider Information	You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
• Claims Inquiry	View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
• Deductible Status	View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
• Hospital Comparison	Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
• Treatment Cost	Find out and compare what different treatments will cost using the Treatment Cost Estimator, **before** you need to make a decision.
• Health Information	Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and BestTreatments organizations.
• Nurseline	Chat online with Registered Nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot get to your doctor.
• Expert Information	Participate in monthly online events with leading experts in health care.

You earn trust.

So do we.

State of Arizona employees, now's the time to join the more than 700,000 Arizonans who already put their trust in Schaller Anderson. You'll have access to comprehensive medical care within our provider network, including an extensive list of specialists, hospitals and urgent care centers. You'll also participate in one of the least expensive EPO options available – all while receiving the same benefits as others. So, during open enrollment, choose a company that has earned Arizona's trust. Choose Schaller Anderson.

Benefit Options
Choice. Value. Health.

Earning trust since 1986.

SCHALLER ANDERSON
HEALTHCARE

www.SchallerAndersonHealth.com

UnitedHealthcare®
A UnitedHealth Group Company

Why UnitedHealthcare?

We put you first.

For too many years, the health care industry has created policies and procedures according to what works for them. UnitedHealthcare's approach is about what works for you and your family.

As a participant with UnitedHealthcare, you have

- Easy, direct access to specialists without having to get a referral
- No prior authorizations needed for most treatments
- Informational tools to help you and your doctor make informed decisions about your care
- Personalized coverage, claims, and physician information on our Web site, **myuhc.com**
- Innovative plan options, programs and informational resources
- Comprehensive, toll-free help line for your health-related and other personal concerns
- Specialized care programs and services when you have serious health concerns

Options PPO Plan

With the Options PPO plan, you have access to more than 16,000 physicians and 57 hospitals throughout Arizona. You do not have to select a primary care physician nor do you need a referral to see specialists in our network. Remember that when you obtain services from contracted physicians in our network you will receive a higher benefit, you will not be subject to balance billing from your physician or health care professional, and you are not responsible for filing the claim; this may not be the case if you choose to use a physician not participating in our network.

Choice EPO Plan

Under the Choice plan, you have access to the same extensive network of physicians and hospitals in Arizona as the PPO plan, and like the PPO plan; you do not have to select a Primary Care Physician to direct your medical care. While we think it's a good idea to have a doctor who is familiar with all your medical history, you are free, at any time, to see any doctor from our extensive network of providers. With the Choice plan, you must always use physicians and health care professionals contracted in the UnitedHealthcare network in order to receive reimbursement for your medical services. The exception to this requirement is in the event of an emergency.

Access to personal information 24/7 on myuhc.com

View eligibility and coverage, including deductible and copay information

- Check claims status
- Find a physician or hospital
- Ask health care professionals – participate in live, online chats
- Request a replacement ID card
- Learn about health conditions, treatments and procedures
- Determine the approximate costs of a procedure using the Treatment Cost Estimator

Health Information and Education – 24 Hours Every Day

Optum® NurseLine℠ is a health information service you can call toll-free 24 hours every day. Our caring staff of experienced registered nurses will provide information, education and support for any health-related concern, at no cost to you.

Additional Benefits from United Behavioral Health

With UnitedHealthcare, you also get mental health and substance abuse benefits. These benefits give you and your covered family members' access to confidential, in-person support for a wide range of concerns, including:

Depression • Substance abuse • Stress and anxiety • Relationship problems • Child/adolescent issues

Strong, Stable and Committed to Arizona

UnitedHealthcare has been in business for over 27 years and we have a long history serving the state of Arizona, providing health care benefits to more than a half million individuals across the state.

If you have questions about your health care benefits, call us at **1-800-896-1067.**

Insurance coverage provided by or through: United HealthCare Insurance Company
Health plan coverage provided by or through: United HealthCare of Arizona

M38005-C 7/05 © 2005 United HealthCare Services, Inc.

It just makes sense.℠

RAN+AMN

Arizona's Exclusive Provider Organization

AZ+EPO

☑ State Network

EPO coverage statewide

☑ RAN+AMN: A Lower Cost Plan

One of Your EPO benefit options

☑ Comprehensive Coverage

10,000 Healthcare providers statewide

☑ Community-Based

Partnering with Arizona hospitals and physicians

Serving AZ since 1981

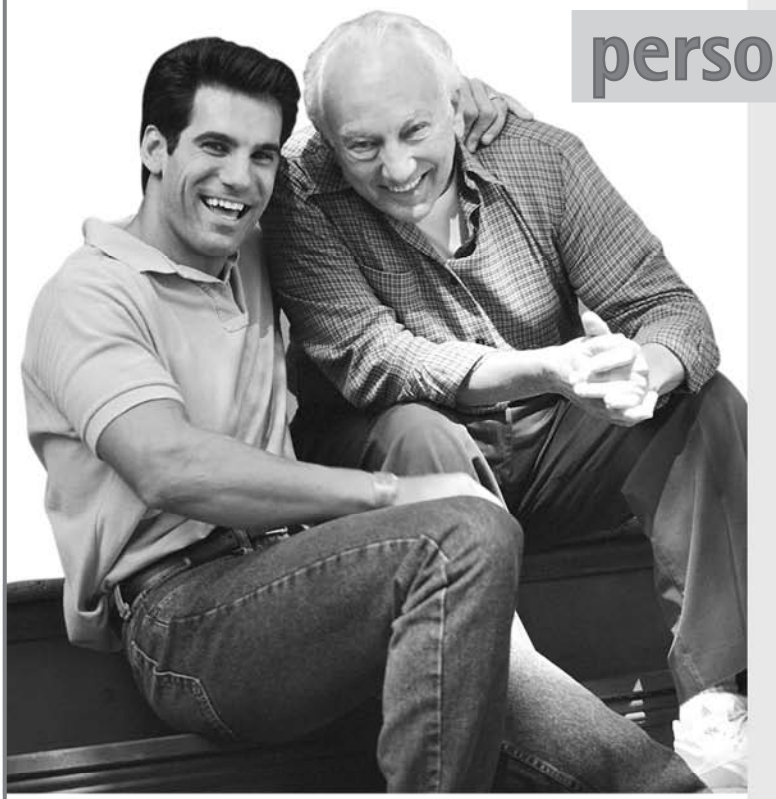
for the health of your family

Benefit Options

Choice. Value. Health.

www.az-epo.com

Harrington



personalized attention

Harrington is a proud partner of AZ Benefit Options. We work with a number of premier provider networks to provide compassionate, accurate and timely claim service, customer service, retiree premium billing, and COBRA premium billing to State of Arizona employees, retirees and their families.

accurate claims

timely service

You will receive all of the advantages of AZ Benefit Options-Harrington through our health care provider networks:

- **Beech Street**
- **Arizona Foundation**
- **RAN+AMN**
- **Schaller Anderson Healthcare**

Please refer to the ADOA service area map to find out which networks are in your area.

Please visit **www.myazhealth.com**, a Website designed specifically for you by AZ Benefit Options—Harrington to find health care providers in your networks, review plan descriptions, find claim forms and information on a variety of health topics. You can check the status of your claims and eligibility as well. For more information, call **888-999-1459**.

Medical Plans Comparison Chart

	EPOs	PPOs	
These plans are available to employees statewide.	RAN/AMN EPO Schaller Anderson Healthcare EPO	Arizona Foundation PPO Beech Street (Out of State only)	
In addition to the plans above, the following plans are offered to employees in Maricopa, Gila, Pinal, Pima and Santa Cruz counties.	UHC Choice EPO	UHC Options PPO	
DEDUCTIBLES/MAXIMUMS	**In-Network (Copayments)**	**In-Network (Copayments)**	**Out-of-Network (Out-of-pocket)**
PCP REQUIRED FOR EACH MEMBER?	NO	NO	NO
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	NO	NO	NO
PLAN YEAR DEDUCTIBLES			
Individual	N/A	N/A	$300
Family	N/A	N/A	$600
OUT-OF-POCKET MAXIMUMS			
Individual	N/A	$1,000	$3,000
Family	N/A	$2,000	$6,000
LIFETIME MAXIMUMS	N/A	N/A	$2,000,000
PHYSICIAN SERVICES Office visits/consultations, Specialist visits/consultations	$10 copay Max of 1 copay/day/provider	$10 copay Max of 1 copay/day/provider	30%
PREVENTATIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Woman Exams (GYN visit & Pap smear test), Annual Well-Man Exams (Office visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10 copay/visit	$10 copay/visit	30%
Mammography Screening (Coverage based on patient age or need)	N/A	N/A	30%
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	N/A	N/A	30%
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	N/A	N/A	30%
Intensive Care	N/A	N/A	30%
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologists	N/A	N/A	30%
EMERGENCY CARE Urgent Center Care	$20 copay	$20 copay	30%
Emergency Room	$75 copay waived if admitted	$75 copay waived if admitted	$75 copay waived if admitted
Ambulance (for medical emergency or required interfacility transport)	N/A	N/A	Emergency paid at in-network benefit rate
PRESCRIPTION DRUGS Copays apply for in-network pharmacies only			
Retail: up to 30-day supply per copay Online/Mail Order: up to 90-day supply for two copays			
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$20 copay	$20 copay	$20 copay
Non-Preferred Brand	$40 copay	$40 copay	$40 copay

Network Plan Coverage for Routine and Urgent/Emergency Care

	EPOs		PPOs	
	UnitedHealthcare	RAN/AMN Schaller Anderson	Arizona Foundation UnitedHealthcare	Beech Street
ROUTINE MEDICAL CARE				
Routine medical care means a regular course of treatment that is anticipated, expected and planned for. Routine medical care is usually conducted in the medical provider's office.				
Central and Southern Arizona	Covered	Covered	Covered	Not Covered
Rural Arizona	Not Covered	Covered	Covered	Not Covered
Traveling in U.S.	Not Covered	Not Covered	Covered	Covered
Living Outside of AZ	Not Covered	Not Covered	Covered	Covered
Guest Privileges [1]	Covered	Covered	Covered	Covered
International Travel	Not Covered	Not Covered	Covered	Covered
URGENT AND EMERGENCY CARE				
Emergency care means the medical, psychiatric, surgical, hospital and related health care services required to stabilize an injury or serious illness that could result in serious medical complications, loss of life or permanent physical impairment.				
Central and Southern Arizona	Covered	Covered	Covered	Not Covered
Rural Arizona	Covered	Covered	Covered	Not Covered
Traveling in U.S.	Covered	Covered	Covered	Covered
Living Outside of AZ	Covered	Covered	Covered	Covered
Guest Privileges	Covered	Covered	Covered	Covered
International Travel	Covered	Covered	Covered	Covered

[1] Members and their dependents may be eligible for guest privileges if they travel or reside outside of Arizona for a minimum of 3 months. You must contact the Plan Administrator to inform them that you will be residing or traveling outside of Arizona and your anticipated date of return to Arizona.

How To Use Your Pharmacy Plan

If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Coverage is part of your medical plan; enrollment is automatic when you enroll in a medical plan and there is no separate cost.

The WHI network consists of more than 54,000 participating chain and independent pharmacies nationwide, with 900 member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address or your dependent student's out-of-state address refer to www.mywhi.com.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for generic drug, $20 for a preferred (formulary) drug and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at www.mywhi.com.

A convenient and less expensive mail-order service is available for employees who require maintenance medications for on-going health conditions or who are going to be in an area with no participating retail pharmacy for an extended period of time. Here are some of the guidelines and benefits of using the mail-order services:

- You must submit a written 90-day prescription from your physician for any new mail order drug.
- You may request up to a 90-day supply of medication for two copays.
- You may pay by check or charge your copay to a Visa, MasterCard, American Express or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at www.mywhi.com or via phone at 1.866.722.2125. One-on-one consultations with a licensed pharmacist are also available at this number.

Before attempting to have a new prescription filled, it is recommended that you check WHI's online formulary to see if the medication might be categorized under one of the following Health Management Programs:

Clinical Prior Authorization
Prescriptions for certain medications or circumstances require approval from your physician before they can be filled, even though you have a valid, current prescription. Prescriptions may be limited to an amount, quantity, frequency, or may have age restrictions. The Clinical Prior Authorization can be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program
Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Health Initiatives (WHI) Specialty Pharmacy. This

program assists you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods and special storage, handling and delivery.

Medications for these conditions through the Specialty Pharmacy Program include, but are not limited to:

- Cystic Fibrosis
- Multiple Sclerosis
- Rheumatoid Arthritis
- Prostate Cancer
- Endometriosis
- Enzyme Replacement
- Precocious Puberty
- Osteoarthritis
- Viral Hepatitis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program.

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

NAU Blue Cross/ Blue Shield Pharmacy Plan

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A, or non-preferred brand B copayment. The BCBSAZ prescription Medication Guide can be used to determine your copayment and this Guide can be found on the BCBS website at https://www.bcbsaz.com/pharmacy. Go to 4 level prescription drug benefit.

Up to a 90-day supply of the maintenance drugs (the same drug and drug strength) may be obtained through the Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copayment for the 90-day supply is equivalent to one month's copayment.

More complete information on your prescription drug benefit can be found in the benefit plan booklet at http://hr.nau.edu/m/. Go to Benefits, Health, BCBS Plan Book.

NAU only *- Refer to more complete information on your prescription drug benefit in the BCBS benefit plan booklet at www.hr.nau.edu/m/; go to Benefits, Health, BCBS Plan Book.*

Online Features of Pharmacy Plan Information

Walgreens Health Initiatives (WHI)

All members enrolled in Arizona Foundation, Beech Street, RAN/AMN, Schaller Anderson Healthcare and UnitedHealthcare can view pharmacy information by registering at www.mywhi.com:

• Co-pay and Drug Information	You may research your medication to learn what co-pay is required at retail or through mail-order service.
• Eligibility Information	Check your eligibility status for you and your family members.
• Search the Formulary	You may research medications to determine whether they are generic, preferred or non-preferred drugs. This classification will determine what co-pay is required.
• Download the Formulary	You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
• Locate a Nearby Pharmacy	You may view pharmacies in your area by zip code or city.
• Prescription History	You may view your entire prescription history, including all of the medications received by each member.
• Mail Service Forms	You may register for mail order service by downloading the registration form and following the step-by-step instructions.
• Refill Information	You may review refill information, including when your next refill can be ordered and available options to request your next refill.
• Drug Information	You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
• Product News	The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

NAU only: *BCBS members can access BlueNet, BlueCross BlueShield of Arizona's online member website at the following address: www.bcbsaz.com/. Information on the pharmacy plan and copayment levels for prescriptions can be found at www.bcbsaz.com/pharmacy; go to 4-level prescription drug benefit.*

Looking to save time *and* money on your prescriptions?

Consider Walgreens Mail Service.

As a member of State of Arizona's pharmacy benefit plan, you can take advantage of the convenient mail service pharmacy option offered through Walgreens Health Initiatives. By filling your maintenance medications (for long-term, chronic conditions) through Walgreens Mail Service, you may save money by paying a lower copay for a 90-day supply and also save time by having your prescriptions delivered right to your door.

To get started, complete and send the Tempe Registration and Order Form that was included in your member materials packet, or visit us online at Mywhi.com and click on "Mail Service Pharmacy." Be sure to have your doctor write a new prescription for a 90-day supply, and mail it in with your registration form. It's that simple.

And, if you have any questions concerning your pharmacy benefits, you can visit Mywhi.com to check copays, find lower-cost alternative medications, view your prescription history, order mail service refills, and more. In addition, the Walgreens Health Initiatives Customer Care Center representatives are available to serve you 24 hours a day, seven days a week. You can reach them toll free at 1-866-722-2141.

With Walgreens Mail Service, you *can* save time and money.

Walgreens Health Initiatives

How To Use Your Dental Plan

Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, www.benefitoptions.az.gov. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your copayment.

Prepaid Plans - Employers Dental Services (EDS) and Fortis Benefits

Prepaid Plans – Employers Dental Services (EDS) and Fortis Benefits

- You see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums ($200.00 maximum reimbursement for non-contracted emergency services under EDS and Fortis).
- No claim forms (except for emergency services under EDS).

Employers Dental Services (EDS)
Employers Dental Services is the largest prepaid dental plan with the largest general dentist network in the State of Arizona. EDS is headquartered in Tucson, Arizona with offices in both Tucson and Phoenix.

Fortis Benefits
Each family member may select his or her own dentist from a group of participating dentists. Each family member may select and change his or her dentist by calling the Fortis Benefits Customer Service number located in the front of this guide. Members may self-refer for specialty care.

Indemnity/PPO Plans - Delta Dental and MetLife Dental

- You may see ANY dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- $1,500 per person per lifetime for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental
Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or copayments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental
MetLife participating dental providers (PDP) accept negotiated fees as payment in full after your deductibles and copayments are met. These fees are typically 15–30 percent below average rates. Noncovered services provided by a PDP dentist are also charged at a lower rate. Covered expenses from a nonparticipating dentist are paid according to established reasonable and customary charges.

Dental Plans

If you live outside of Arizona you should select one of the two Indemnity/PPO dental plans. The prepaid plans cover ONLY emergency care outside of Arizona.

	In Arizona	Outside Arizona, In U.S.	International
PRE-PAID PLANS			
Assurant (Fortis)			
Routine Care	X		
Emergency Services	X	X	X
Employers Dental Services			
Routine Care	X		
Emergency Services	X	X	X
PPO PLANS			
Delta Dental			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X
MetLife			
Participating Dentist Services	X	X	
Non-Participating Dentist Services	X	X	X

3547 State Benefits Dir 7/29/05 11:52 AM Page 1

What makes Delta Dental so special?

That's a question that can probably be answered half a million different ways.

Some of our more than 500,000 Arizona members will say it's the Delta Dental dentists. No other plan gives you more than 2300 dentists to choose from, with offices all across Arizona and more than 146,000 across the nation. For others, it's the across-the-board quality that Delta Dental represents, whether you ask brokers, employers or the patients themselves. And for some, well, they simply like that we're a locally run business, that our service representatives are friendly, know their stuff and provide solutions quickly. Can half a million customers be wrong? **If you have 5 employees or more, find out by visiting www.deltadentalaz.com or call (888) 267-6453.**

DELTA DENTAL®

Delta Dental of Arizona

Rated No.1 for the past six consecutive years according to the *Business Journal Book of Lists* and *Ranking Arizona* magazine.

IS YOUR DENTAL CARE COMPLETE?

Now you can plan for unexpected dental care costs with the MetLife® Preferred Dentist Program (PDP)!

Here's what you get with the PDP:

- ✔ **Freedom of choice:** Freedom to visit any dentist whether or not you participate in the PDP. Plus, you don't need to pre-select a primary dentist or obtain referrals to see a specialist.
- ✔ **Broad network access:** Access to a seamless national network of over 78,000 carefully credentialed participating PDP dentists including over 15,000 specialists.
- ✔ **Valuable cost savings:** Typically save 10% to 35% below the average fees of dentists in your area when you visit a participating PDP dentist. These dentists agree to accept scheduled fees as payment-in-full for services rendered.
- ✔ **Valuable benefit coverage:** Competitive coverage for preventive services as well as protection from costs associated with more complex dental procedures.
- ✔ **Superior claim service:** Having a great experience with us is our commitment to you. That's why MetLife processes 85% of claims in five business days or less, to get your claim paid faster. And, if you have questions, simply call 1-800-942-0854 or log on to www.metlife.com/mybenefits, to access all the tools and information you will need to be a better-informed user of your dental plan.

Join us and see what everyone is smiling about!

MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, NY 10166

Printed in U.S.A.
PEANUTS © United Feature Syndicate, Inc.
L0507173O(exp0706) MLIC-LD

Dental Plans Comparison Chart

	Employers Dental Services/EDS*	Fortis Benefits*	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	100% paid, after applicable copay	100% paid, after applicable copay		
Office Visit	$5/visit	$5/visit**	100% paid, deductible waived	100% paid, deductible waived
Oral Exam	No copay	No copay	100% paid, deductible waived	100% paid, deductible waived
Prophylaxis/Cleaning	$5 copay	$3 copay	100% paid, deductible waived	100% paid, deductible waived
Fluoride Treatment	No copay for children	No copay	100% paid, deductible waived	100% paid, deductible waived
X-Rays	No copay	No copay	100% paid, deductible waived	100% paid, deductible waived
BASIC RESTORATIVE	Fixed copays***	Fixed copays		
Office Visit	$5/visit	$5/visit	80% paid	80% paid
Sealants (to age 19)	$12/tooth	$5/tooth	80% paid	80% paid
Fillings	$12-$25 (amalgam)	$10-$20 (amalgam)	80% paid	80% paid
Extractions	$15 (single)	$15 (single)	80% paid	80% paid
Periodontal	Copay/procedure	$50/quadrant**	80% paid	80% paid
Oral Surgery	Copay/procedure	Copay/procedure**	80% paid	80% paid
MAJOR RESTORATIVE	Fixed copays***	Fixed copays		
Office Visit	$5/visit	$5	50% paid	50% paid
Crowns	$225-$275 (plus lab fees)	$235	50% paid	50% paid
Dentures	$300 (plus lab fees)	Copay/procedure	50% paid	50% paid
Fixed Bridgework	Copay/procedure	Copay/procedure	50% paid	50% paid
Crown/Bridge Repair	$5 (plus lab fees)	$20-$45 (plus lab fees)	50% paid	50% paid
Inlays	$112-$125	$130-$240 (plus lab fees)	(Allowance given)	(Covered expense)
ORTHODONTIA	By Treatment Plan	By Treatment Plan		
Child	25% discount off Plan Specialist's normal retail	25% discount off Plan Specialist's normal retail	50% paid	50% paid
Adult	25% discount off Plan Specialist's normal retail	25% discount off Plan Specialist's normal retail	50% paid	50% paid
TMJ Services	Fixed copays	Fixed copays		
Exams, services, etc.	Up to 25% of normal fees	$85-$115	No coverage	No coverage
MAXIMUM BENEFITS	No dollar limit	No dollar limit		
Annual combined preventive, basic and major services	Benefits paid for participating dentists and/or orthodontists only	Benefits paid for participating dentists and/or orthodontists only	$2,000/person	$2,000/person
Orthodontia Lifetime			$1,500/person	$1,500/person

* *Requires you to select a Participating Dental Provider (PDP) when enrolling. Out-of-state members are eligible for emergency care only with EDS and Fortis.*

** *A Specialty Benefit Amendment is included in the Fortis Benefits plan that allows patients to receive certain services from Fortis's contracted specialists for a specific copayment rather than the discounted fee.*

*** *Copays listed are for services provided by your EDS General Dentist (PDP). EDS specialists offer up to 25% off their normal office fees for covered procedures.*

How to Use Your Vision Plan

Coverage for vision examinations and corrective eyewear is available to all benefits-eligible employees and their qualified dependents through Avesis, Inc. Employees are responsible for the full premium cost of this voluntary plan.

You may receive services from either a participating or a non-participating provider once a plan year according to the schedule below; exceptions are the Lasik benefit which is available one time only and the additional eyewear benefit which you may use as many times as you wish.

To use a participating provider, either go online at www.avesis.com or call 800.828.9341 to select an in-network facility, call the provider and identify yourself as an Avesis member and schedule your appointment.

If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and provide your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services.

Participating Provider Fee Schedule

Participating Provider	Co-Pay	Benefit/Allowance After Co-Pay
1) Vision examination and **one** of the following:	$10	
a) Single, bifocal, trifocal or lenticular lenses and frame		$100-$150 retail value
Progressive lenses and frame		20% off retail minus $50 allowance for lenses and $100-$150 retail value of frame
b) Contact Lens: Elective		$130 toward fitting fee and/or contacts
Contact Lens: Medically Necessary*		Covered 100%
c) Lasik Surgery		$150 toward one or both eyes
2) Additional options		20% discount from provider's fee (i.e., tints, coatings)
3) Additional eyewear		Avesis contracted discounted fee

* Contact lenses would be considered medically necessary for the following conditions: a) post cataract surgery; b) keratoconus; c) certain condition of anisometropia; d) extreme visual conditions that cannot be corrected with spectacle lenses. Determination of medical necessity is made by Avesis.

Nonparticipating Provider Fee Schedule

Non-Participating Provider	Allowance Up To:
Vision Examination	$50
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lenses	$55
Lenticular Lenses	$110
Progressive Lenses	$45
Frames	$50
Contact Lenses	
Elective	$150
Medically Necessary*	$300
Lasik Surgery	Not Covered

Over 30,000 Arizona State Employees trust Avesis as their vision care provider.

*With the Avesis Vision Plan, employees can save up to $150 per year on exam, frames, spectacle lenses or contacts. Families can save over $500! **

Are you one of them?

Avesis continues to be the State of Arizona's vision care provider for a fifth straight year.

Join your colleagues.

Sign up for the Avesis voluntary vision plan during this open enrollment season.

VISION BENEFITS

Avēsis
A National Vision and Dental Company

3724 North 3rd Street
Suite 300
Phoenix, AZ 85072

FOR MORE INFORMATION ABOUT YOUR STATE OF ARIZONA VISION BENEFITS PLEASE CONTACT CUSTOMER SERVICE AT 1-800-828-9341 OR VISIT WWW.AVESIS.COM/ARIZONA

*Actual savings may be more or less depending on frame selection, lens options and special purchases.

National and International Coverage
(Medical, Dental and Vision)

Member Coverage Outside of Arizona

	Travel Within the U.S.	International Travel
MEDICAL CARE		
EPO Plans		
RAN/AMN	Emergency and Urgent Only	Emergency and Urgent Only
Schaller Anderson	Emergency and Urgent Only	Emergency and Urgent Only
UnitedHealthcare	Emergency and Urgent Only	Emergency and Urgent Only
PPO Plans		
Arizona Foundation	Covered as out-of-network	Covered as out-of-network
Beech Street	Covered as in-network if services provided through a network provider; Out-of-network if services provided through a non-network provider.	Covered as out-of-network
UnitedHealthcare	Covered as in-network if services provided through a network provider; Out-of-network if services provided through a non-network provider.	Covered as out-of-network
PHARMACY BENEFITS		
Walgreens Health Initiatives	Benefits are covered in-network. If you obtain medications through a non-network pharmacy, you will not be reimbursed. You may call 1.866.722.2141 to locate a pharmacy in the area in which you are traveling.	Prescriptions cannot be mailed outside of the U.S. You may receive a one-year supply for certain prescriptions through mail order service prior to leaving the U.S. Please call 1.800.345.1985 to make arrangements. If you obtain medications outside of the U.S., you will not be reimbursed.
DENTAL CARE		
Pre-Paid Plans		
Assurant (Fortis/United)	Emergency Only	Emergency Only
Employers Dental Services	Emergency Only	Emergency Only
PPO Plans		
Delta Dental	Benefits are covered as in-network through participating providers and non-network under non-participating provider benefits.	Coverage is available under non-participating provider benefits.
MetLife Dental	Benefits are covered as in-network through participating providers and non-network under non-participating provider benefits.	Coverage is available under non-participating provider benefits.
VISION CARE		
Avesis	Covered using in-network providers. You may call 1.800.828.9341 to locate a vision provider in the area in which you are traveling.	Covered as out-of-network and will be reimbursed based on the Avesis reimbursement schedule.

Flexible Spending Accounts

Once your employment is terminated:

- You may continue to submit claims for expenses incurred through your termination date but not incurred after your termination date.
- You forfeit any remaining monies unless you elect to continue FSA contributions through COBRA until the end of the plan year.

If you elect to continue FSA through COBRA, your contributions will be post-tax and the amount will be calculated as follows: An additional 2% per pay period for the remaining number of pay periods will be charged in addition to the original pay period amount for administration for FSA under COBRA.

In order to assist you in calculating expenses for medical and/or dependent care, a form has been provided to aid you at www.benefitoptions.az.gov under the flexible spending account link for "Employees."

Important Information About Your COBRA Coverage Rights

What is COBRA coverage?
Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee/retiree spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed more in detail in separate paragraphs below).

COBRA coverage is the same coverage that the State of Arizona group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the "State") under the Plan (i.e., medical, dental, vision and health care FSA) and not to any other benefits offered by the State (such as life insurance, disability, or accidental death and dismembermember). The Plan provides no greater COBRA rights than what COBRA requires - nothing in this notice is intended to expand your rights beyond COBRA's requirements.

How can you elect COBRA coverage?
To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver by the date specified on the Election Form to the ADOA Benefits Office as indicated on the Election Form. Each qualified beneficiary has a separate right to elect COBRA

coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under Health Care FSA

COBRA coverage under the health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the health care FSA, if elected, will consist of health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year and COBRA coverage will terminate at the end of the Plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits office (see "For More Information" section on page 38).

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you avoid such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition

exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above). You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How Long Will COBRA Coverage Last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may only be continued for up to a total of 18 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage under the Plan as a result of the qualifying event can last up to 30 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the Plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any preexisting condition exclusions of another plan that applies to the qualified beneficiary have been exhausted or satisfied);
- the State ceases to provide any group health plan for its employees; or
- during a disability extension (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the applicable carrier (see "For More Information" section on page 38) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other

group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrator may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How Can You Extend the Length of COBRA Coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will affect the right to extend COBRA coverage. (The period of COBRA coverage under the health care FSA cannot be extended beyond the end of the current Plan year under any circumstances.)

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18 month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the applicable carrier (see "For More Information" section on page 38) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date of which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termnation or reduction of hours.

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary

became disabled;

- the date that the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" section on page 38).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

This extension due to a second qualifying event is available only if you notify the applicable carrier (see "For More Information" section) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event;
  the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if requested by the ADOA Benefits Office. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice within the required time periods to the ADOA Benefits Office at the addresses

indicated on page 38 (see "For More Information" section).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How Much Does COBRA Coverage Cost?
Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The required monthly payment for each group health benefit provided under the Plan under which you are entitled to elect COBRA is described in this notice.

When and how must payment for COBRA coverage be made?

First Payment for COBRA Coverage.
If you elect COBRA coverage, you do not have to send any payment with the Election Form.

However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date of your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered). If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. If your employment ended on January 31st, you would pay for coverage from February 1st through the end of the month in which you are making the payment. You are responsible for making sure that the amount of your first payment is correct. You may contact ADOA Benefits Office to confirm the correct amount of your first payment.

Monthly Payments for COBRA Coverage. After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each coverage period for each month for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notice of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time).

Grace Periods for Monthly Payments. Although

monthly payments are due on the first day of each month of COBRA coverage, you will be given a 30 day grace period after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month's coverage. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Your first payment for COBRA coverage should be sent to the following:

Note: Although initial payment is mailed directly to ADOA, payments must be made payable to the applicable carriers for which you are electing coverage.

ADOA Benefits Office
100 N. 15th Avenue, Ste. 103
Phoenix, AZ 85007

Checks should be made payable to:

- UnitedHealthcare for any of the UHC plans
- Harrington Benefit Services for any of the following plans: Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson
- Dental premiums should be made payable to the dental carriers: Delta, MetLife, EDS or Fortis/Assurant
- Vision premiums should be made payable to Avesis

After the initial payment, your monthly payments will be sent to the individual administrator/ carrier. You will receive an invoice each month that will include the applicable address.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments received or postmarked after the due date will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries
Children born to or placed for adoption with the covered employee during COBRA coverage period.
A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption.

To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for

example, regarding age).

Alternative recipients under QMCSOs. A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the covered employee's period of employment with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

For more information
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights to COBRA coverage, you should contact the following:

ADOA Benefits Office
100 N 15th Ave., Suite 103
Phoenix, AZ 85007
602.542.5008 or
800.304.3687.

Information is also available from the:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850
410.786.1565

Keep your plan informed of address changes
In order to protect you and your family's rights, it is important that you keep the ADOA Benefits Office and the applicable health plan administrator(s) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the ADOA Benefits Office and or the applicable health plan administrator(s).

NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In The Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you with to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at www.benefitoptions.az.gov. The ADOA Privacy Officer may be contacted at 100 N. 15th Avenue, Suite 401, Phoenix, Arizona 85007.

EFFECTIVE DATE

This Notice is effective April 14, 2003.